the Hungarian case-control surveillance of congenital abnormalities, however, was unable to confirm that griseofulvin used during pregnancy has a teratogenic effect.[6]

In my opinion, the anxiety and fear created by the notion that nearly all drugs cause congenital abnormalities may be more harmful than the drugs themselves.

ANDREW E CZEIZEL
Medical geneticist

Department of Human Genetics and Teratology,
National Institute of Public Health,
WHO Collaborating Centre for the Community Control of Hereditary Diseases,
Budapest,
Hungary

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Medic Alert UK should start new section for patients with a difficult airway

EDITOR,—The Medic Alert Foundation is a worldwide charitable and voluntary organisation dedicated to disseminating information to doctors about potential hazards for individual patients. In anaesthesia its greatest contribution is to warn anaesthetists that a patient has a life threatening reaction to a drug, so that the drug can be avoided.

An unsuspected difficult airway can be life threatening in patients presenting for general anaesthesia. According to one survey, almost one third of all adverse anaesthetic outcomes are related to respiratory problems,[1] and about 41% of all deaths attributable to anaesthesia are related to difficulties with endotracheal intubation.[2] Unfortunately, preoperative tests on the airway have poor predictive value: nearly half of difficult intubations are not predicted preoperatively.[3] Knowledge of previous problems with a patient's airway is of paramount importance. Generally, however, patients have only a vague idea of problems that occurred when they were given anaesthetics in the past. Usually, and especially out of hours, efforts to get the details of the previous incident and its management are futile, and so the patient is at risk of a further critical incident.

With patients' full consent, Medic Alert keeps relevant data, which can be obtained by authorised medical staff on a 24 hour basis. I propose that a national "difficult airway register" should be established (which could be based at St George's Hospital), to which all anaesthetists could supply relevant information on a standard form. Registered patients would then be approached to become members of Medic Alert UK, so that their record giving details of their difficult airway could be stored with this organisation and the information retrieved, if required, at any time. General practitioners would have access to this information and could include it in their referral letter to the hospital.

In the United States a comprehensive system for disseminating information about patients with a difficult airway, which incorporates Medic Alert, has operated for the past few years. Preliminary results indicate that access to this detailed information leads to fewer techniques being used by anaesthetists and a reduction in adverse outcomes.[4]

J B LIBAN
Consultant anaesthetist

Department of Anaesthesia,
St George's Hospital,
London SW17 0QT

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Describing race, ethnicity, and culture in medical research

"White" populations also need to be accurately described

EDITOR,—Kwame McKenzie and N S Crowcroft's comments about the recording of race, ethnicity, and culture are sensible and sensitive.[1] Their choice of examples, however, may inadvertently reinforce the misconception—widely held in the health service and not helped by the classification of the Office for National Statistics (formerly the Office of Population Censuses and Surveys)—that "ethnic" equates with "non-white." There is enormous ethnic and cultural variability in "white" populations, with both political implications (as in Ulster and Bosnia) and medical implications (for example, heart disease and diabetes). When appropriate, similar precision should be used in describing white population groups. I speak as a professional Malta-born, polyglot, Catholic pasta eater of Maltese, Irish, and English extraction who has been resident in Britain for 35 years.

DAVID DE BONO
Professor

Department of Cardiology,
University of Leicester,
Glenfield General Hospital,
Leicester LE3 9QP

1 McKenzie K, Crowcroft NS. Describing race, ethnicity, and culture in medical research. *BMJ* 1996;312:1054. (27 April.)

Self defined ethnicity is unhelpful

EDITOR,—Kwame McKenzie and N S Crowcroft's editorial and recommendations on describing race, ethnicity, and culture are an important contribution to the debate on ethnic classification.[1,2] While the authors discuss the complexities associated with ethnic classification of various non-white British groups, their recommendations fail to acknowledge the similar difficulties in describing what could be referred to as the indigenous population (that is, those who have been traditionally termed white). There is an implicit assumption in much of the work on inter-ethnic differences that this group represents an ethnic standard by which members of other ethnic groups may be judged.[3] Our findings indicate that when people traditionally classified as "white British" are asked to define their ethnic background a range of complex responses is elicited.

As part of a larger study at Northwick Park Hospital examining psychosocial aspects of chronic disability due to low back pain, we attempted to determine the ethnic group to which patients felt they were affiliated. A question was designed that was based on five items (ethnic origin, religion, country of birth, length of time in Britain, and languages spoken); we thus used a similar approach to that recommended in McKenzie and Crowcroft's guidelines[2] and used free text fields, because of the move towards the use of such fields in ethnic monitoring in the health service.[4]

Table 1—*British patients' self defined ethnicity and country of birth*

Ethnic identity	Country of birth	No
English	England (45), London (1), United Kingdom (3)*	51
British	Britain (2), England (20), United Kingdom (3), Wales (2)	27
White	Britain (2), England (7), Ireland (1)	10
White European	Ireland (2), United Kingdom (1)	3
Caucasian	England (1), Northern Ireland (1)	2
British Gibraltar	Gibraltar (1)	1
British White	England (1)	1
British//Irish parents	United Kingdom (1)	1
British Philippines	India (1)	1
English/Australian	United States (1)	1
English/Irish	England (1)	1
European	England (1)	1
Scottish	Egypt (1)	1
United Kingdom	United Kingdom (1)	1
White British	England (1)	1
White English	England (1)	1
Total		104

*Two patients did not state their country of birth.

Out of 297 patients, 235 (79%) responded to the question on self defined ethnicity. Analysis by *t* test indicated that this group was significantly younger (P = 0.029) than the 62 who failed to respond to this question. Altogether, 104 respondents were identified as "British" (table 1). Sixteen distinct responses fell in this category. The three most common responses were English, British, and white (total 88 patients); the 13 further groups comprised 16 patients.

Our data show the heterogeneity of this ethnic group—patients who were categorised as British. Thus, while use of the term "Asian" to describe people of Indian, Pakistani, Bangladeshi, and Sri Lankan origin is often said to lack specificity as the definition of an ethnic group,[5] a similar case could be made for the ethnic term "British."

We conclude that it is more profitable for health service research to use a range of variables, such as language, religion, country of origin, and length of residence in the country, to investigate the impact of cultural differences. We recommend that ethnicity, even if self defined, should not be used on its own as a variable.

JAMES MCAULEY
Postgraduate research student
LORRAINE DE SOUZA
Director of postgraduate physiotherapy studies
VIDYUT SHARMA
Research assistant

Brunel University College,
Isleworth TW7 5DU

IAN ROBINSON
Director

Centre for the Study of Health, Sickness, and Disease,
Department of Human Sciences,
Brunel University,
Uxbridge UB8 3PH

CHRIS J MAIN
Head

Department of Behavioural Medicine,
Salford Royal Hospitals NHS Trust,
Manchester University
Manchester M13 9PL

A O FRANK
Consultant physician in rehabilitation and rheumatology

Northwick Park and St Mark's NHS Trust,
Harrow HA1 3UJ

1 McKenzie K, Crowcroft NS. Describing race, ethnicity and culture in medical research. *BMJ* 1996;312:1054. (27 April.)

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Links need to be maintained with census definitions

EDITOR,—The definition and meaning of terms relating to race, ethnicity, and culture are issues to which social scientists have devoted hours and pages of thought. Some doubt whether they are indeed real entities (like "society"), but, as many studies have now shown, they are real in their effects. Kwame McKenzie and N S Crowcroft's editorial and "style guide" are helpful pointers out of the maze.[1 2]

It is important to emphasise that culture and ethnicity are multivariate. Researchers should (for example) make reference to religion as it is likely to be a key factor in behaviour. The style guide seems to omit language, which, at least in relation to people of South Asian descent, may provide as much useful information as does religion—and certainly more than the catch-all term "Indian."

The guidance also emphasises the need to let people identify their own ethnicity.[2] It is therefore good news for those who, like me, have advocated this and promoted ethnic monitoring that general practitioners in Leicester and Lincolnshire found the procedure so easy to operate.[3] Hopefully, such open debate will reassure those who, by virtue of their uncertainty about the value of ethnic monitoring, make the collection of data problematic. The results will be of little value, however, unless linked to sound estimates of the population denominator. For this reason it is imperative that, however freely people are allowed to choose or describe their identity, a link is maintained to the complex and carefully designed structures used in the census.[4] Without some degree of agreement we shall see no benefit in epidemiology or the delivery of services and a backlash against the collection of data may result.

The provision of well thought out guidelines is a useful start and may help to avoid the confusion that seems to have developed in the United States.[5] We may now look forward to an end of the muddled thinking embodied in such old and ugly terms as "Europid" and the confusion between nationality as stated in a passport, which has no clinical importance, and ethnic group, which manifestly does.

MARK R D JOHNSON
Senior research fellow

University of Warwick,
Coventry CV4 7AL

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Guidelines will encourage the thinking that underpins racism in medicine

EDITOR,—I am concerned that Kwame McKenzie and N S Crowcroft's editorial on the need to describe race, ethnicity, and culture in medical research will encourage prejudice.[1] I am sure that that is not the authors' intention, but it is what they are most likely to accomplish if they continue in their present line of thought. They offer the spurious argument that "if researchers want to be able to compare results of studies now and in future, a framework is needed for the classification of ethnic and cultural groups." Not so. There are more meaningful criteria on which people can be compared, such as sex, age, place of residence, environmental conditions, occupation, income, and lifestyle.

McKenzie and Crowcroft go on to suggest that we need to "agree on how culturally and ethnically to demarcate the people of the world." Why? Can the authors not see that most of our problems are the direct result of just such demarcation? What do they understand to be the underlying cause of such phenomena as racism, "ethnic cleansing," the caste system in the Indian subcontinent, the pogroms in Rwanda and Burundi, and the "troubles" in Northern Ireland?

I am sorry that the *BMJ* lends credibility to the views of these two authors by producing guidelines on describing people by ethnicity, race, or culture in research, audit, and publications.[2] This only encourages the thinking underpinning the racism that is endemic in the selection of medical students and in the training, employment, and promotion of doctors in Britain.

We need to take a conscious decision not to "demarcate" people but to encourage people to think non-racially and non-ethnically. As one of the most widely read international journals, the *BMJ* is uniquely placed to take a leading role in this process. I would not support censorship, but I would support the *BMJ*'s rejection of all letters, articles, and papers that seek to divide people into distinct racial, ethnic, or cultural groups. This is not just because of a wish to stop supporting prejudice but also because, to quote the *BMJ* itself, "race has limited biological validity" and "culture is difficult to measure and describe."[2] Lifestyle does, but race, culture, and ethnicity do not, merit inclusion in our list of valid epidemiological variables.

IKECHUKWU OBIALO AZUONYE
Consultant psychiatrist

South Western Hospital,
London SW9 8EA

1 McKenzie K, Crowcroft NS. Describing race, ethnicity and culture in medical research. *BMJ* 1996;312:1054. (27 April.)
2 Ethnicity, race, and culture: guidelines for research, audit, and publication. *BMJ* 1996;312:1094. (27 April.)

Authors' reply

EDITOR,—We agree with David de Bono's comments and the findings of James McAuley and colleagues that there is as much variability in "white" groups as in any other. In fact, we had suggested that a "white" example should be included in the guidelines to make this very point. Unfortunately, this was not done. Part of the motivation for our editorial and the guidelines was to dissipate the myth that groups defined by skin colour are homogeneous in any meaningful sense other than that which corresponds to racialised thinking.

Mark R D Johnson points out the importance of language and of maintaining links between self coding and census categories so that population denominators are available. McAuley and colleagues' letter, however, underlines the limitations inherent in the use of any particular classification on its own.[1] Furthermore, individuals may change their self coded ethnic group as society changes, making interpretation of time trends problematic.

Ikechukwu Obialo Azuonye speaks from the heart when he calls for a world where racial, ethnic, and cultural differences are not important. We would all like to live in such a world, but we do not at present, and we have to deal with the problems of this one. There are ethnic differences in the rates of illness and in the uptake of health services.[2] There is racism in society. Research that recognises these facts can lead to better policies and services to combat inequity, and to a better understanding of the aetiology of diseases. How could appropriate interventions be developed if we were unable to measure and compare the effects of racism, genetics, poverty, and culture?

Thousands of papers are published every year that refer to race, ethnicity, or culture. If we are to use such information effectively to improve health and health care then we need a coherent framework within which to report and interpret findings. We wrote our editorial and the guidelines in the hope that such a framework could be agreed internationally and to start a correspondence on the subject. We hope that letters such as these published here will lead to the guidelines being refined so that they meet the needs of both researchers and the subjects of research.

KWAME MCKENZIE
Honorary research fellow
King's College Hospital Medical School and Institute of Psychiatry,
London SE5 8AX

NATASHA CROWCROFT
Fellow
European Programme for Intervention Epidemiology Training,
Institute of Hygiene and Epidemiology,
Brussels 1050,
Belgium

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Addison's disease

Secondary adrenal failure in critically ill patients is underrecognised

EDITOR,—C M Brosnan and N F C Gowing's lesson of the week is a succinct reminder of the diverse presentation of primary adrenal failure and emphasises the risk of shock that is unresponsive to inotropes in these patients.[1] There is a growing realisation that secondary adrenal failure can also occur in critically ill patients and is probably more common than previously thought.[2] Establishing the diagnosis may be difficult in these patients, since they do not exhibit the normal electrolyte abnormalities of adrenal failure and usually have a serum cortisol concentration in the normal range for the healthy population. Typically, however, they present with septic shock that is unresponsive to inotropes and has no apparent focus of infection.[3]

Treatment with physiological doses of steroids leads to a rapid resolution of the shock, and inotropes can usually be withdrawn within 48 hours of the start of such treatment.[4] The adrenal failure is normally transient, so the steroids can be tapered off once the patient's general condition improves.

Adrenal failure in critically ill patients is underrecognised and may be life threatening. The diagnosis should be considered in any patient in whom septic shock occurs without an obvious source of infection.

C GRANGER
Senior registrar

Department of Anaesthesia,
Blackpool Victoria Hospital,
Blackpool FY3 8NR

1 Brosnan CM, Gowing NFC. Addison's disease. *BMJ* 1996;312:1085-7. (27 April.)